3 Service Coordination Guidelines

3.1 General Policy

3.1.1 Definition

Service coordination services are services that are delivered by qualified providers to assist Medicaid participants who are unable, or have limited ability, to gain access to, coordinate, or maintain services on their own or through other means. Refer to IDAPA 16.03.17 for rules regarding Service Coordination.

- Service coordination services are limited to the following target populations:
  - Adults with Developmental Disabilities
  - Adults with Severe and Persistent Mental Illness
  - Individuals who are receiving personal care services or who are receiving Home and Community Based Services for the aged and physically disabled
  - Children through the month of their 21st birthday under EPSDT

Note: Service Coordination for participants enrolled in the **Medicaid Basic Plan Benefits** is limited to diagnostic and evaluation procedures only**.** Participants enrolled in the **Medicaid Enhanced Plan Benefits** are eligible for additional service coordination services.

See **Section 3.2** for the eligibility requirements for these target populations.

- Service coordination is a brokerage model of case management and does not include the provision of direct services.
- Service coordination consists of the following functions:
  - Assessment. Evaluation of the participant's ability to gain access to needed services; coordinate or maintain those services; and identify services and supports the participant needs to maintain his highest level of independence in the community. (For assessment requirements see IDAPA 16.03.17.300)
  - Plan development. Except for service coordination for participants with a mental illness, a written service plan must be developed within sixty (60) days after the participant chooses a service coordination agency. The plan for participant's with mental illness must be developed with thirty (30) days after the participant chooses a service coordination agency. The plan must be updated at least annually. The plan must address the service coordination needs of the participant as identified in the assessment. (For service plan content requirements see IDAPA 16.03.17.400)
  - Linking the participant to needed services. Finding, arranging and assisting the partcipant to maintain services, supports, and community resources identified on the service

Note: Service Coordination services are not covered for **CHIP-B** participants.

Refer to the **CHIP-B Appendix section B.1.5** for service limitations for **CHIP-B** participants.

plan; and advocating for the unmet needs of the participant; and ecouraging independence.

- Monitoring and coordination of services. Assisting the participant and family/guardian to retain, assure the consistency and non-duplication between services; and assure participant satisfaction and making adjustments in the plan when necessary.

- Service coordinators must have contact with the participant, legal guardian or provider who can verify the participant's well being and whether services are being provided according to the written plan at least every 30 days. The frequency, mode of contact, and person being contacted must be identified in the plan. Mental health service coordinators must have face-to-face contact with each participant every month. Developmental disability and PCS service coordinators must have face-to-face contact with each participant at least every ninety days. EPSDT service coordinators must have face-to-face contact with the child and the child's family at least every ninety days.

- Service coordinators do not have to be available on a twenty-four (24) hour basis, but must include on the written plan what the participant, families, and providers should do in an emergency situation.

3.1.2 Payment

Medicaid reimburses service coordination services on a fee-for-service basis or a flat monthly rate. Usual and customary fees are paid up to the Medicaid maximum allowance.

- Service Coordination services to adults with mental illness or who are receiving personal care or waiver services are reimbursed on a fee-for-service basis.

- Service Coordination services to adults with a developmental disability or for children under the EPSDT program are reimbursed through a flat monthly rate.

3.1.3 Non-covered Services

- Service Coordination does not include the provision of direct service.

- Medicaid does not pay for service coordination services that duplicate services or payments for the same purposes.

- Medicaid does not pay for ongoing service coordination delivered prior to the completion of the service coordination plan. Services provided to a group of participants is not covered.

- Medicaid does not pay for service coordination when the participant is incarcerated.

- Medicaid does not pay for service coordination for missed appointments, attempted contacts, travel to provide the service, leaving messages, scheduling appointments with the Medicaid coordinator, transporting participants, or documenting services.

3.1.4 Service Limitations

Service Coordination services for different populations have different limitations. They are:

- Service Coordination for adults with mental illness is limited to five (5) hours per month.
- Service Coordination for individuals receiving personal care services or aged/disabled waiver services is limited to 8 hours per month as prior authorized by the Department.

Medicaid does not pay for service coordination services provided to participants who are inpatients in nursing facilities (NF), intermediate care facilities for the mentally retarded (ICF/MR), or hospitals, except under the following conditions:

- Service coordination services rendered on the admit or discharge date from a long term care facility or hospital, as long as the participant is not yet admitted or has been discharged at the time of the service delivery.
- Service coordination services may be rendered during the last 30 days of an inpatient stay or when the inpatient stay is not expected to last longer than 30 days. Service coordination services cannot duplicate services that are included in the responsibilities of the facility.

The total caseload of a service coordinator must not exceed a number over which the service coordinator can assure quality service delivery and participant satisfaction.

Note: Failure to adequately document service delivery may result in the recoupment of money paid for such services.

3.1.5 Payment Limitations

Participants are only eligible for one (1) type of service coordination. If they qualify for more than one (1) type, the participant must choose one (1).

Service coordination payment must not duplicate payment made to public or private sector entities under other program authorities for this same purpose.

Payment for Service Coordination is only allowed for the following services:

- Face to face contact between the service coordinator and the participant, participant's family members, legal representative, primary caregivers, providers, or other interested persons.
- Telephone contact between the service coordinator and the participant, participant's service providers, family members, primary care givers, legal representative, or other interested persons.
- Paperwork that is associated with obtaining needed services such as food stamps, energy assistance, emergency housing, or legal services.

Payment for ongoing service coordination will not be made prior to the completion of the assessment and service plan.

For service coordination, paid as fifteen (15) minute time increments, providers will not be reimbursed for more than one (1) contact during a single fifteen (15) minute period.

Failure to provide services for which reimbursement has been received is cause for recoupment of payment, sanctions, or both.

3.1.6 Participant Choice

All Medicaid participants have free choice in the decision to receive or not receive service coordination services. Documentation indicating the participant's choice must be kept with their record.

3.1.7 Record Requirements

The following documentation must be maintained by the provider as required in 16.03.17.752.01 through 10:

- Name of the participant
- Name of agency and person providing service
- Date, time and place of service
- Documentation of eligibility
- A copy of the assessment and service plan signed by participant or legal representative and the plan developer. Mental health service coordination plans must also be signed by physician or other licensed practitioner of the healing arts within the scope of his/her practice under state law (or as indicated in each specific program rule). The service coordinator must also document that a copy of the plan was given to the participant or legal representative. Plan must be updated and authorized when required, but at least annually.
- Description of the service provided signed by the person who delivered the service.
- Documented review of progress toward each service plan goal
- Assessment of the participant's need for targeted service coordination and other services as the participant's needs change
- Informed consent
- Documentation of the participant's, family's, or guardian's satisfaction with service
- For adults with Mental Illness, documentation to support authorization of crisis assistance beyond the monthly limitation. See IDAPA 16.03.17.752.10 for detailed description of the content of the documentation.

3.1.8 Prior Authorization

Some service coordination services require prior authorization. When a service is prior authorized, the approval is valid for one year from the authorized date unless otherwise indicated.

For Healthy Connections participants, prior authorization will be denied if the requesting provider is not the primary care provider or a referral has not been obtained. A Healthy Connections referral is not required for service coordination services for individuals receiving personal care or A&D waiver services.

For more information on prior authorization, see **Section 2.3.2**.

Service coordination for adults with mental illness does not require prior authorization for the first five hours of service each month. Providers must document the need for service coordination in the participant's records. See Section 3.4.1 for Crisis Assistance Authorization.

Service coordination for individuals receiving personal care services (PCS) or A&D waiver services requires two prior authorizations from the Regional Medicaid Services (RMS). They are as follows:

- The participant must be approved by the RMS for service coordination. The RMS will authorize the assessment and service plan development.
- Based on the Individual Community Support Plan (ICSP), the RMS authorizes hours of ongoing service coordination.

Service coordination for adults with developmental disabilities requires prior-authorization by the IAP in accordance with IDAPA 16.03.13. Service coordinators must update the approved plan for service coordination at least annually.

Service coordination for children under EPSDT requires prior authorization and a service plan completed by DHW or its designee for the initial service plan prior to delivery of service coordination services. The service coordinator must review and update the approved Service Plan for service coordination at least annually. The Regional Children's DD program must approve the plan for continued prior-authorization.

3.1.9 Procedure Codes

All service coordination services must be billed using the appropriate HCPCS codes.

Please note that some codes may require the use of a designated modifier code when billing appropriate services codes.

Service	HCPCS Code	Description
Mental Health Service Coordination Assessment (TCM/MI)	H0031	Mental Health Assessment, by Non-Physician (Initial Assessment and Individual Service Plan development). All other assessments and service plan updates should be billed as ongoing. 1 unit = 15 minutes Limited to 24 units for the initial assessment and plan.
Mental Health Service Coordination Ongoing (TCM/MI)	T1017	Targeted Service Coordination, each 15 minutes (ongoing service coordination). Effective 7/1/03, limited to 5 hours of non-crisis ongoing service coordination monthly and 3 hours of crisis ongoing service coordination.

Service	HCPCS Code	Description
Personal Care Assessment and ICSP Development (PCS)	G9001 Use modifier U2 when Individual is on A&D waiver	Coordinated Care Fee, Initial Rate (Assessment and ICSP). This is a one-time rate. Requires prior authorization by the regional ACCESS unit.
Personal Care Service Coordination Ongoing (PCS)	G9002 Use Modifier U2 when individual is on A&D waiver	Coordinated Care Fee, Maintenance Rate (Ongoing and emergency PCS service coordination.. Indicate the total number of 15-minute units billed. Requires prior authorization by the regional ACCESS unit.
DD Service Coordination, Initial (TSC)	G9001	Coordinated Care Fee, Initial Rate (Initial service coordination) Flat monthly rate for the first six calendar months. 1 unit = 1 month initial service coordination
DD Service Coordination, Ongoing (TSC)	G9002	Coordinated Care Fee, Maintenance Rate (Ongoing service coordination) Flat monthly rate for the calendar months after the initial six months. 1 unit = 1 month ongoing service coordination
EPSDT Service Coordination Initial (ESC)	G9001 Use modifier EP	Coordinated Care Fee, Initial Rate (Initial EPSDT service coordination). Flat monthly rate for the first six calendar months. At least one contact with the participant, legal guardian or a provider who can verify the participant's well being and whether services are being provided according to the written plan must occur within each month billed for.. 1 unit = 1 month
EPSDT Service Coordination, Ongoing (ESC)	G9002 Use modifier EP	Coordinated Care Fee, Maintenance Rate (Ongoing EPSDT service coordination) Flat monthly rate for the calendar months after the initial six months. At least one contact with the participant, legal guardian or a provider who can verify the participant's well being and whether services are being provided according to the written plan must occur within each month billed for.. 1 unit = 1 month
EPSDT , Crisis Assistance (ESC)	G9003	Coordinated Care Fee, Risk Adjusted High, Initial (Emergency service coordination). Prior authorization is required by regional ACCESS unit. 1 unit = 15 minutes

3.1.10 Place of Service Codes

Enter the appropriate numeric code in the place of service box on the CMS 1500 claim form or in the appropriate field when billing electronically.

03 – School

11 – Office

12 – Home

22 – Outpatient hospital

23 – Emergency Room: hospital

31 – Skilled nursing facility

32 – Nursing facility

33 – Custodial care facility

53 – Community mental health center

54 – Intermediate care facility/mentally retarded (ICF/MR)

71 – Public health clinic

99 – Other unlisted facility

3.1.11 Diagnosis Codes

Enter the appropriate primary ICD-9-CM diagnosis code for the participant's condition in field 21 on the CMS-1500 claim form. If billing electronically, enter the diagnosis code in the designated field on the screen.

Exception:

Use diagnosis code V604 — No Other Household Member Able to Render Care, as the primary diagnosis code for personal care case management.

3.2 Service Coordination Eligibility

Participants identified below who do not receive hospice services or live in hospitals, nursing facilities, or intermediate care facilities for the mentally retarded, are eligible for service coordination:

Adults with a Developmental Disability as defined in Section 66-402 of Idaho Code are eligible for Service Coordination if they:

- Are eighteen (18) years of age or older, or adolescents fifteen to eighteen (15-18) years of age who are authorized to receive services through the Idaho State School and Hospital (ISSH) waiver; and
- Are diagnosed with a developmental disability; and
- Have **impairments that result** in substantial functional limitations in three (3) or more of the following areas of major life activity: self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self-sufficiency; and
- Need a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and individually planned and coordinated.
- Require and choose assistance to adequately access services and supports necessary to maintain their independence in the community.

Individuals who receive personal assistance services are eligible for Service Coordination if they:

- Are adults or children who have been approved to receive state plan personal care services; or
- Are adults who have been approved to receive aged and disabled home and community based waiver services; and
- Require and choose assistance to access services and supports necessary to maintain their independence in the community.

Adults with Severe and Persistent Mental Illness are eligible for Service Coordination if they:

- Are 18 years of age or older; and
- Have a severe and persistent mental illness with a diagnosis identified in IDAPA 16.03.17.203.02.a

- Have functional limitations due to a mental illness identified in 16.03.17.203.03.a through h
- Have a history of using high cost medical services including hospital services with frequent exacerbations of mental illness

Children up to the age of 21 are eligible for Service Coordination if they:

- Are between birth and the month of their twenty first birthday; and
- Are identified by a physician or other practitioner of the healing arts in an EPSDT screen (Well-child Check) as needing Service Coordination services; and
- Have one of the following:
    - Developmental delay or disability; or
    - Special health care needs requiring medical and multidisciplinary habilitation or rehabilitation services to prevent or minimize a disability; or
    - Severe emotional disorder under DSM-IV-TR with an expected duration of at least one year; and
- Have one or more of the following problems associated with their diagnosis:
    - The condition has resulted in a level of functioning below normal age level in one or more life areas such as school, family or community; or
    - They are at risk of placement in a more restrictive environment or they are returning from an out of home placement as a result of the condition; or
    - There is danger to their health or safety or the parents are unable to meet their needs; or
    - Further complications may occur as a result of the condition without provision of service coordination services; or
    - They require multiple service providers and treatments.

Note: Service Coordination for participants enrolled in the **Medicaid Basic Plan Benefits** is limited to diagnostic and evaluation procedures only**.** Participants enrolled in the **Medicaid Enhanced Plan Benefits** are eligible for additional service coordination services.

3.3 Provider Qualifications

3.3.1 Service Coordinators

All Service Coordinators must be employees or contractors of an agency that has a valid provider agreement with the Department.

- Agencies that hire employees must meet all requirements for an agency listed in the general provider agreement including worker's compensation and general liability insurance.
- An agency includes a minimum of at least a supervisor and a service coordinator.
- Agencies may not provide both service coordination and direct services to the same Medicaid participant except for: Service Coordination for children under EPSDT and Service Coordination for adults with severe and persistent mental illness.

All Service Coordinators must have a minimum of a bachelor's degree in a human services field from a nationally accredited university or college; or be a licensed professional nurse (RN).

- A human services field is a particular area of academic study in health, social services, education, behavioral science or counseling.

All Service Coordinators must have a least twelve (12) months experience working with the population they will be serving or be supervised by a qualified service coordinator.

Work experience must be at least twenty (20) hours per week.

All Service Coordinators must pass the Department's criminal history check in IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks".

3.3.2 Paraprofessionals

Under the supervision of a qualified service coordinator, paraprofessionals may be used to assist in the implementation of a service coordination plan except for plans of participants with a mental illness.

- Paraprofessionals may not conduct the assessments or develop service coordination plans.
- Paraprofessionals must be able to read and write at a level equal with the paperwork and forms involved in the provision of service.
- Paraprofessionals must pass the Department's criminal history check as described in IDAPA 16.05.06 "Rules Governing Mandatory Criminal History Checks".

3.3.3 Supervision of Service Coordination

Service coordination agencies must provide supervision to qualified service coordinators and paraprofessionals employed or under contract with the agency. Agency supervisors must have the following qualifications:

- Be an employee or contractor of an agency that has a valid provider agreement with the Department

and

- Master's degree in a human services field (see 3.3.1.2) and one (1) year's experience with the population for whom they will be supervising services;

  For supervisors of service coordination for participants with mental illness, this experience must be in a mental health service setting

  or

- Bachelors degree in a human services field (see 3.3.1.2) or R.N. degree and two (2) years' experience with the population for whom they will be supervising services

  For supervisors of service coordination for participants with mental illness, this experience must be in a mental health service setting

  and

- Must pass the Department's criminal history check in IDAPA 16.05.06 "Rules Governing Mandatory Criminal History Checks"

3.4 Crisis Service Coordination

Crisis service coordination services are linking, coordinating and advocacy services provided to assist a participant to access emergency community resources in order to resolve a crisis. Crisis service coordination does not include crisis counseling, transportation to emergency service providers, or direct skill-building services.

Crisis assistance, including services to prevent hospitalization or incarceration may be provided before the completion of an assessment and development of a plan of service.

Note: Service Coordination for participants enrolled in the **Medicaid Basic Plan Benefits** is limited to diagnostic and evaluation procedures only**.** Participants enrolled in the **Medicaid Enhanced Plan Benefits** are eligible for additional service coordination services.

3.4.1 Crisis Assistance for Adults with a Developmental Disability

Crisis assistance for adults with a developmental disability may be authorized under community crisis supports as found in IDAPA 16.03.13 "Prior Authorization for Behavioral Health Services" Section 400 **if at least four (4) hours of service coordination has already been provided that month.**

Process to request MI Crisis Hours:

1.Complete "Request for Additional Service Coordination Hours" form

2. Email or fax to Central Office Behavioral Care Management Unit

froehlics@idhw.state.id.us

(208) 364-1911

3. Attach

Request for hours

SC Assessment and Treatment Plan

Applicable notes

3.4.2 Crisis Assistance for Adults with Severe and Persistent Mental Illness

Three (3) hours of crisis assistance per month may be provided without authorization by the Department or its designee. The Department may authorize additional crisis service coordination services beyond the three (3) hour limit if a participant still has severe or prolonged crisis service coordination needs that meet all of the following criteria:

- The service participant is at imminent risk (within fourteen (14) days) of hospitalization or institutionalization, including jail or nursing home; and
- The service participant is experiencing symptoms of psychiatric decompensation; and
- The service participant has already received the maximum number of monthly hours of ongoing service coordination and crisis service coordination services; and
- No other crisis assistance services are available to the participant under other Medicaid mental health option services, including Psychosocial Rehabilitation Services (PSR).

3.4.3 Crisis Assistance for Individuals Who Receive Personal Assistance Services/A&D Waiver Services

Additional hours for crisis assistance may be authorized for individuals who receive personal assistance services, if at least eight (8) hours of service coordination has already been provided in the month.

3.4.4 Crisis Assistance for Children Receiving EPSDT Service Coordination

Additional crisis hours may be authorized for service coordination for children receiving EPSDT service coordination if at least four (4) hours of service coordination has already been provided in the month.

3.5 Claim Form Billing

3.5.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA-compliant vendor software.

To submit electronic claims, use the HIPAA-compliant 837 professional transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

All claims must be received within one year of the date of service.

See **Section 2.2.2**, for more information on electronic claims submission.

3.5.2 Electronic Claims

For PES software billing questions, consult the Idaho PES Handbook. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

3.5.2.1 Guidelines for Electronic Claims

Detail Lines
Idaho Medicaid allows up to 50 detail lines for electronic HIPAA 837 Professional claims.

Referral number
A referral number is required on an electronic HIPAA 837 Professional claim when a participant is referred by another provider. Use the referring provider's Medicaid provider number, unless the participant is a Healthy Connections participant. For Healthy Connections participants, enter the provider's Healthy Connections referral number.

Prior Authorization (PA) numbers
Idaho Medicaid allows more than one prior authorization number on an electronic HIPAA 837 Professional claim. PAs can be entered at the header or detail of the claim.

Modifiers
Use of up to **four** modifiers per detail is allowed on an electronic HIPAA 837 Professional claim.

Diagnosis codes
Idaho Medicaid allows up to **eight** diagnosis codes on an electronic HIPAA 837 Professional claim.

Electronic crossovers
Idaho Medicaid allows providers to submit electronic crossover claims for professional services.

3.5.3 Guidelines for Paper Claim Forms

For paper claims, use only original CMS-1500 claim forms (formerly known as the HCFA 1500) to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

The CMS-1500 form can be used without changes for dates in the year 2000 and beyond. All dates must include the month, day, century, and year.

Example: July 4, 2005 is entered as 07/04/2005

3.5.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MM/DD/CCYY) format. Note that in field 24A (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field 24A.
- You can bill with a date span (From and To Dates of Service) only if the service was provided on consecutive days within the span.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be denied that are not signed.
- Do not use staples or paperclips for attachments. Stack them behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).

3.5.3.2 Where To Mail the Paper Claim Form

Send completed claim forms to:

EDS
P.O. Box 23
Boise, ID 83707

3.5.3.3 Completing Specific Fields on the Paper Claim Form

Consult the Use column to determine if information in any particular field is required. Only fields that are required for billing the Idaho Medicaid program are shown on the following table. There is no need to complete any other fields. Claim processing will be interrupted when required information is not entered into a required field.

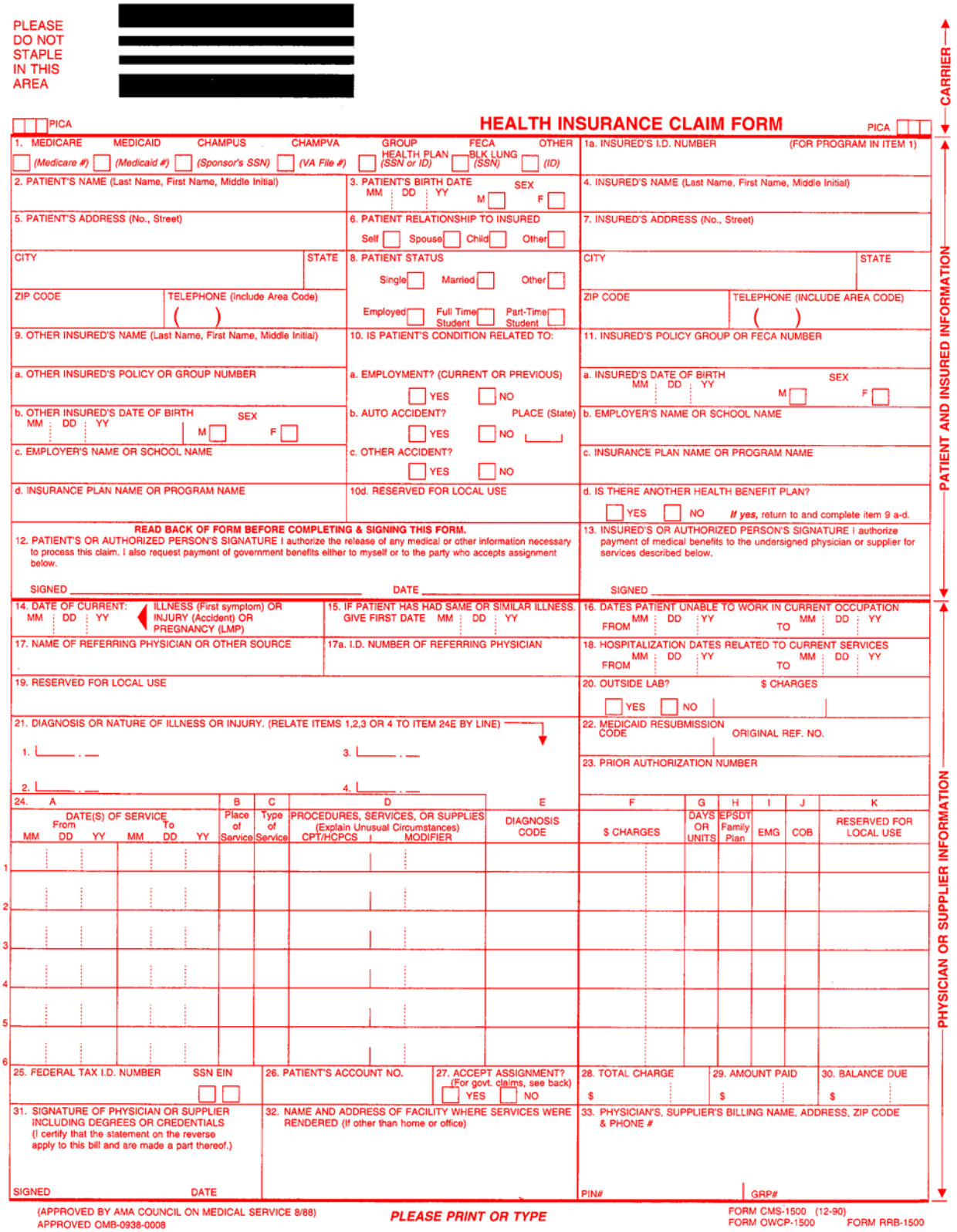
The following numbered items correspond to the CMS-1500 claim form.

Field	Field Name	Use	Directions
1a	Patient ID	Required	Enter the seven-digit participant ID number exactly as it appears on the plastic participant ID card.
2	Patient's Name	Required	Enter the participant's name exactly as it appears on the Medicaid plastic ID card. Be sure to enter the last name first, followed by the first name and middle initial.
9a	Other Insured's Policy or Group Number	Required if applicable.	Required if field 11d is marked YES. If the participant is covered by another health insurance or medical resource, enter the policy number.
9b	Other Insured's Date of Birth/Sex	Required if applicable.	Required if field 11d is marked YES. If the participant is covered by another health insurance or medical resource, enter the date of birth and sex.
9c	Employer's Name or School Name	Required if applicable.	Required if field 11d is marked YES.
9d	Insurance Plan Name or Program Name	Required if applicable.	Required if field 11d is marked YES. If the participant is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Condition Related to Employment?	Required	Indicate yes or no if this condition is related to the participant's employment.
10b	Auto Accident?	Required	Indicate yes or no if this condition is related to an auto accident.
10c	Other Accident?	Required	Indicate yes or no if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check yes or no if there is another health benefit plan. If yes, return to and complete items 9a-9d.
14	Date of Current: Illness, Injury or Pregnancy	Desired	Enter the date the illness or injury first occurred, or the date of the last menstrual period (LMP) for pregnancy.
15	If Patient Has Had Same or Similar Illness	Desired	If yes, give first date, include the century. For pregnancy, enter date of first prenatal visit.
17	Name of Referring Physician or Other Source	Required if applicable.	Use this field when billing for a consultation or Healthy Connections participant. Enter the referring physician's name.
17a	ID Number of Referring Physician	Required if applicable	Use this field when billing for a consultation or Healthy Connection participant. Enter the referring physician's Medicaid provider number. For Healthy Connections participants, enter the provider's Healthy Connections referral number.

Field	Field Name	Use	Directions
19	Reserved for Local Use	Required if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. This field can also be used to enter the ICN of previous claims to establish timely filing.
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to 4) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required if applicable	Enter the prior authorization number from DHW, RMS, ACCESS, RMHA, EDS, Quality Improvement Organization (QIO), or MTU.
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, year). **Example:** November 24, 2005 becomes 11242005 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24D 1	Procedure Code Number	Required	Enter the appropriate five-character CPT or HCPCS procedure code to identify the service provided.
24D 2	Modifier	Required if applicable	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as three. Otherwise, leave this section blank.
24E	Diagnosis Code	Required	Use the number of the subfield (1-4) for the diagnosis code entered in field 21.
24F	Charges	Required	Enter your usual and customary fee for each line item or service. Do not include tax.
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H1	EPSDT Screen (Well-child check)	Required if applicable	Not required unless applicable. If the services performed constitute an EPSDT program screen, refer to the instructions for EPSDT claims in the provider handbook.
24I	EMG	Required if applicable	If the services performed are related to an emergency, mark this field with an **X**.
24K	Reserved for Local Use	Required if applicable	When a group, agency, or clinic is the billing agency, enter the Idaho Medicaid provider number of the provider rendering the service in Field 24K and the group provider number in field 33.
28	Total Charge	Required	Add the charges for each line then enter the total amount.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance payment including Medicare. Attach documentation from an insurance company showing payment or denial to the claim including the explanation for the denial reason.
30	Balance Due	Required	Enter the total charges, less amount entered in amount paid field.

Field	Field Name	Use	Directions
31	Signature and Date	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See Section 1.1.4 for more information.
33	Provider Name and Address	Required	Enter your name and address exactly as it appears on your provider enrollment acceptance letter or RA. If you have had a change of address or ownership, please, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
33	GRP — Provider Number	Required	Enter your nine-digit Medicaid provider number.

3.5.3.4 Sample Paper Claim Form



PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statement on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION